Camper Health Form Summer 2027
One per camper please!

camping & retreat center
LUTHER PARK
danbury, wisconsin

Camper Name _____Birthdate _____

Emergency Contacts:

#1 Name _____ Phone _____ Relation to Camper _____

#2 Name _____ Phone _____ Relation to Camper _____

#3 Name _____ Phone _____ Relation to Camper _____

Allergy & Dietary Restrictions

Does your child have any allergies?

- ☐ No
- ☐ Yes, allergic to: _____

  Allergic reaction details, date, and description: _____

Does your child require an EpiPen?

- ☐ No
- ☐ Yes. Please provide details about your child's anaphylaxis, including the date and description of last reaction. _____

  *If marked "Yes" above, would you like your camper to carry their EpiPen on themselves throughout the day
  - ☐ Yes
  - ☐ No. I would like the Health Care Manager to carry my child's EpiPen.
  - ☐ No. I would like my child's Cabin Leader to carry my child's EpiPen.

Does your child have any dietary restrictions?

- ☐ No
- ☐ Yes, dietary restrictions include _____

Medications & Treatments

Will your child be taking any medications while at camp?

- ☐ No
- ☐ Yes. Medication _____ Dose _____ Time taken _____ Reason _____
  Medication _____ Dose _____ Time taken _____ Reason _____
  Medication _____ Dose _____ Time taken _____ Reason _____
  Medication _____ Dose _____ Time taken _____ Reason _____

If your child uses an Inhaler or Insulin, would you like them to carry it on themselves?

- ☐ Does not apply to my child.
- ☐ Yes
- ☐ No. I would like the Health Care Manager to carry my child's inhaler or insulin.
- ☐ No. I would like my child's Cabin Leader to carry my child's inhaler or insulin.

Will your child require any treatment while at camp?

- ☐ No
- ☐ Yes. Please explain: _____

Camper Name _____

Does your child regularly take any medication that will not be taken at camp?

- ☐ No
- ☐ Yes. Please explain: _____

Check the following over-the-counter medications that MAY be given to your child while at camp, if needed?

- ☐ Acetaminophen (Tylenol)
- ☐ Antacids
- ☐ Antibiotic Cream
- ☐ Antihistamines (Benadryl, Diphenhydramine)
- ☐ ASA (Aspirin) Adults only unless directed by an MD.
- ☐ Calamine Lotion
- ☐ Hydrocortisone Cream
- ☐ Dimetapp
- ☐ Insect Repellent
- ☐ Pepto-Bismol
- ☐ Robitussin or cough drops
- ☐ Robitussin DM
- ☐ Sting Swabs
- ☐ Sudafed
- ☐ Sunburn Spray (Solarcaine) or Aloe Vera
- ☐ Sunscreen

Immunizations

Please list the date of your child's most recent vaccination or booster, if any, for the following

Tetanus Booster----------Immunized on _____ ☐ Not Immunized

Chicken Pox (Varicella)---------- Immunized on _____ ☐ Not Immunized

Diptheria, Tetanus, Pertussis (DTap)--Immunized on _____ ☐ Not Immunized

Polio---------- Immunized on _____ ☐ Not Immunized

MMR---------- Immunized on _____ ☐ Not Immunized

Haemophilus Influenza B---------- Immunized on _____ ☐ Not Immunized

Hep A---------- Immunized on _____ ☐ Not Immunized

Hep B---------- Immunized on _____ ☐ Not Immunized

Meningococcal Meningitis (MCV4)--- Immunized on _____ ☐ Not Immunized

Pertussis/Tdap or Td booster---------- Immunized on _____ ☐ Not Immunized

Health History

Has your child experienced, or is currently experiencing, any of the following conditions?

ADD/ADHD ☐ No ☐ Yes. Please explain _____

Asthma/Inhaler ☐ No ☐ Yes, mild, moderate, or severe? Is it sports induced? _____

Bedwetting ☐ No ☐ Yes. Please explain _____

Behavioral Issues ☐ No ☐ Yes. Please explain _____

Blackouts/Fainting ☐ No ☐ Yes. Please explain _____

Bleeding Disorder ☐ No ☐ Yes. Please explain _____

Chest Pain ☐ No ☐ Yes. Please explain _____

Concussion ☐ No ☐ Yes. Please explain _____

Constipation/Diarrhea ☐ No ☐ Yes. Please explain _____

Convulsions ☐ No ☐ Yes. Please explain _____

Depression ☐ No ☐ Yes. Please explain _____

Developmental Delays ☐ No ☐ Yes. Please explain _____

Diabetes ☐ No ☐ Yes. Date of diagnosis & care needed _____

Eating Disorder ☐ No ☐ Yes. Please explain _____

Frequent Colds ☐ No ☐ Yes. Please explain _____

Headaches ☐ No ☐ Yes. Please explain _____

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Hearing Problems □ No □ Yes. Please explain _____

Heart Disease □ No □ Yes. Please explain _____

Homesickness □ No □ Yes. Please explain _____

Lice □ No □ Yes. Please explain _____

Mental Health Issues □ No □ Yes. Please explain _____

Nightmares/Terrors □ No □ Yes. Please explain _____

Problems Breathing or Coughing □ No □ Yes. Please explain _____

Seizures □ No □ Yes. Please explain _____

Skin Problems □ No □ Yes. Please explain _____

Sleepwalking □ No □ Yes. Please explain _____

Speech Problems □ No □ Yes. Please explain _____

Stomach Aches □ No □ Yes. Please explain _____

Has your child had any operations?

□ No

□ Yes. Please explain _____

Has you child ever been hospitalized or had a serious injury?

□ No

□ Yes. Please explain & list date(s) _____

Has you child been exposed to any communicable diseases within the last 3 months?

□ No

□ Yes. Please explain & list date(s) _____

Does your child have any restrictions on activity?

□ No

□ Yes. Please explain _____

Will you child require and special assistance while at camp?

□ No

□ Yes. Please explain _____

Please list any other medical information the camp should know about your child & if you would like to discuss anything with the medical staff.

_____

_____

Health Insurance and Doctor Information

Family Doctor _____ Phone Number _____

Family Dentist _____ Phone Number _____

Do you have medical insurance? □ No □ Yes

Health Insurance Policy Holder Information

Full name of Policy holder _____ Policy holder phone _____

Employer name (if through employer) _____

Health Insurance Company Information

Insurance Company/Plan Name_____ Insurance company phone _____

Health Insurance Policy Number _____ Insurance group name or number _____

Camper Name _____

Medical Waiver

My child has permission to engage in all camp activities, except as noted by myself and the examining physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, to order injection, anesthesia or surgery for my child as named above. I give permission for the camp to provide routine healthcare and dispense medications. I voluntarily waive any claim against the sponsoring institution, local churches and camp personnel for any mishap or lost articles, or any and all causes which may arise in connection with activities of Luther Park Camping and Retreat Center.

_____ _____

Parent/Guardian Signature Date

Luther Park – 30376 Lakes Dr. Danbury, WI 54830 – 715.200.7023 – www.lutherparkdanbury.com - madison@lutherpark.com